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ABSTRACT

This newsletter theme issue discusses collaboration between professionals and families whose children have emotional disorders. Background information is provided on the concept of empowerment and the development of collaboration as a principle for delivering services. Factors that lead to empowerment and barriers experienced by families are addressed. Information is also provided on: the Vanderbilt Family Empowerment Project in Tennessee, which developed a parent group curriculum and research program to study the effects of family empowerment; a University of Kansas project at the Beach Center on Families and Disability to define, measure, and evaluate family-centeredness of services targeted toward children and their families; the University of Vermont's Family/Professional Collaboration Project to promote family and professional collaboration at all levels of planning, service delivery, and policymaking for children with special health needs; the Multnomah County Partners Project in Portland, Oregon, to coordinate community-based services for children who are receiving services from two or more government systems; and upcoming projects of the Research and Training Center of Portland (Oregon) State University. Parents' perspectives on these collaborative efforts are provided. (SW)

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[Family-Professional Collaboration]

Marilyn McManus, Ed.

Focal Point
Volume 9, Number 1
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FOCAL POINT

A NATIONAL BULLETIN ON FAMILY SUPPORT & CHILDREN'S MENTAL HEALTH

EMPOWERING FAMILIES WHOSE CHILDREN HAVE EMOTIONAL DISORDERS

Empowerment is a concept that has come of age in the human services. Entire conferences and books are devoted to the topic, and new programs often claim that empowerment of consumers or clients is a central goal in delivering services. Inevitably, the widespread focus on empowerment by practitioners, policy-makers, researchers, and consumers has led to different understandings of what is meant by the term. However, a good working definition is that of Lee Staples (1990) who views empowerment as an ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies (p. 30). One nice feature of this definition is that it speaks of empowerment as a capacity rather than as a process by which power or resources are conveyed from one to another. Some people have objected to the use of the term empowerment because it implies a transfer of something that is already rightfully possessed by the receiver. For example, how can a professional empower a parent to make decisions about her or his child when the parent already has that right? Viewing empowerment as a capacity leaves open the question of how people become empowered, a complex issue we will touch upon later.

Historically, the concept of empowerment is rooted in concerns for social justice where attention has been directed toward groups or communities who lack resources and influence relative to the greater society. Here, efforts to address the needs of such groups start with the premise that empowerment is a necessary part

of any program that attempts to redress traditional imbalances. In other words, it is not sufficent to merely provide disadvantaged groups with resources; rather, it is also important to foster a process whereby such groups have both control over current resources and a greater capability to obtain future resources. This process fundamentally alters the relationship with the larger society by shifting the tone of the relationship from paternalism and dependency to reciprocity, self-reliance, and mutual respect.

While this emphasis on the empowerment of groups is still very current in human services, the concept of empowerment has been adapted to describe the experiences of individuals as well. For example, Barbara Solomon (1976), in her seminal work on empowerment in African American communities, identified self-evaluations as key indicators of empowerment. Other authors have since used similar ideas to describe feelings of personal effectiveness and capability. Considering the large amount of recent discussion on empowerment,

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JUST WHAT IS "COLLABORATION"?

Mention the word collaboration and what comes to mind? Sports fans envision a championship team. Music devotees may think of a highly creative band or group. Old movie buffs may be reminded of one of the great film-star duos like Hepburn and Tracy. Collaboration occurs in many forms and in many endeavors. We admire the accomplishments of an individual, but we reserve special admiration for collaborative efforts that produce something truly outstanding. We recognize that one of the accomplishments of collaboration is not just a product but an underlying, successful relationship that allows individuals to achieve something that they could not do alone.

Now mention the word collaboration in the context of human services. What comes to mind? An *administrator* may experience apprehension about how services shared among several agencies are to be managed and allocated. A *practitioner* may be reminded of his or her concerns about re-defining traditional notions of responsibility and professionalism. A *parent* may experience confusion about how to become involved in a decision-making process that is unfamiliar and perhaps unwelcoming. The word collaboration may signify—for each of these three individuals—an idea that is intriguing but ill-defined and unspecified. Partnerships are readily understood in other areas of everyday life, but in human services, many ask "Just what is 'collaboration'?"

Part of the difficulty in defining

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We invite our audience to submit letters and comments.

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EMPOWERING FAMILIES WHOSE CHILDREN HAVE EMOTIONAL DISORDERS

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there now seems to be some consensus that empowerment can be thought of in three distinct ways: (1) the empowerment of individuals with respect to their own circumstances; (2) the empowerment of individuals with respect to others; and (3) the empowerment of groups in relationship to the larger society. Like many concepts in the social sciences, empowerment has evolved from its origins and has now taken on a larger meaning.

At the Research and Training Center on Family Support and Children's Mental Health, we have taken this general view of empowerment and applied it specifically to families whose children have emotional disabilities. Our approach, which is based on both the literature and discussions with parents, also considers three types of empowerment. One type concerns handling problems within the family at home. Here, parents feel empowered to the extent that they are generally able to solve problems that arise and are confident in their ability to help their children grow and develop. Another type of empowerment concerns dealing with the service system—mental health providers, educators and others—on behalf of one's own child. This is a type of interpersonal empowerment that reflects both parents' rights to make decisions about services and their knowledge about what to do to get better services. A third type of empowerment concerns influencing the service system and the community to improve services for all children with emotional disorders. This is political empowerment in the sense that efforts here are not only made on behalf of one's own child, but on behalf of all children. Not all parents demonstrate each type of empowerment; for example, most parents are not especially active in the community or in political activities. Some families are, however, involved in community or political activities, and certainly the leaders in the emerging family organizations across the United States, are illustrative of parents with a high degree of community and political empowerment.

Some initial research using this three-way perspective on empowerment has shown promising results. A questionnaire based on this approach has been developed and tested on a sample of 440 parents from four family organizations from Oregon, Wisconsin, Mississippi and Washington, D.C. (Koren, DeChillo & Friesen, 1992). An analysis of parents' responses showed that the questionnaire provides reliable measures of each type of empowerment, and this finding was subsequently affirmed with additional samples of parents whose children were either involved in long-term services or just beginning services. Reliability, which is concerned with how much trust can be placed in a measurement procedure, is a basic requirement for applying any questionnaire in research. Therefore, these findings pave the way for additional research that looks more closely at empowerment. In Portland, two current studies are examining the effects of innovative services on empowerment, and similar efforts in other parts of the country are also underway.

While studies of the effects of different services on empowerment may provide valuable insight on how empowerment may be facilitated, they only partially address the complicated question of what leads people to become empowered. The question is at the heart of any scientific effort to understand empowerment, since science fundamentally involves a specification of cause and effects. The question is also crucial to program development efforts that seek to facilitate the empowerment of families—if we do not know what leads to empowerment, we can hardly design programs to promote it.

Since research on empowerment is so new, there are almost no studies that identify key factors that lead to empowerment. However, what can be said at this point is that there are multiple and complex factors involved, and there is more than one way to get there. For example, some of the more exciting recent developments in the field of children's mental health have emphasized parent-professional collaboration and family participation as important methods of promoting parental empowerment. Here, collaboration and participation are considered as important factors that promote or facilitate empowerment and, implicitly, the absence of such factors is considered detrimental to empowerment. The Research and Training Center has always promoted parent-professional collaboration and family participation as guiding principles for delivering services, and these continue to be major underlying values for the Center.

Yet, discussions with many parents as well as qualitative research conducted by the Center suggests that many parents become empowered despite services that discourage collaboration and participation. The scenario is a fairly common one:

(a) Parents search for services and resources for their children and families become frustrated in their encounters with the service system;

(b) Parents realize that they have to find services and resources on their own and, in the process, discover

their own capacities and abilities;

(c) Parents learn how services are organized in their communities, develop new abilities to negotiate the service system, gain the confidence to deal with professionals, and acquire case management skills to help their own children. In short, parents become empowered.

From the standpoint of cause and effect, clearly these parents do not need collaborative professionals to become empowered. Rather, their own resiliency and perseverance must be credited, as well as perhaps other factors that have yet to be identified.

The point here is not to assert that professionals do not make a difference. On the contrary, we believe that a collaborative approach that emphasizes mutual decisions and values family participation greatly facilitates empowerment, and that, if the parents described above had perhaps encountered such professionals, their road may have been easier to travel. Our point is that the path to empowerment is more complex and convoluted than some of the current discussions might imply. Moreover, any real attempt to understand empowerment must move beyond simple, single-cause notions to encompass a variety of personal, family and community-based issues that are operative in any given family's situation.

What is the future of empowerment as a concept in the human services? The signs are both good and bad. On the positive side, empowerment as a service-delivery principle is gaining a great deal of acceptance, and its incorporation into mainstream practice has probably come too far to be turned back. This is significant, since empowerment represents a fundamental shift in the perspective taken by the helping professions toward the individuals, families and groups with whom they work. Far from being just another technique, the philosophy of empowerment entails both a re-statement of values and a re-working of the concept of professionalism. The traditional underpinnings of professional practice based on authority and power are superseded by notions of partnership, shared decision-making, and mutual respect. Such a major change in perspective, we believe, cannot help but have an effect on improving services and the way services are delivered. Moreover, in a time of increasingly reduced resources and service cutbacks, the empowerment approach simply makes good sense.

On the negative side, the concept of empowerment is in danger of being trivialized due to both overuse and tokenism. Service providers may make statements about empowering consumers but continue to conduct business as usual. Program administrators may tell funding sources that empowerment is a principal goal of services but continue to evaluate outcomes with traditional measures and methods. There is no doubt that the field of human services (and social science as well) is particularly prone to "faddish" thinking whereby concepts that are in vogue at one time fade away only to be replaced by something different—but not necessarily better. To prevent empowerment from suffering the same fate, the concept must continue to be developed in practice and in research.

With respect to practice, service providers and administrators should consider the fundamental implications of the empowerment approach in their development of services; in other words, walk the talk. This means actively soliciting consumer input and feedback and modifying services accordingly. This also means evaluating services in ways that treat empowerment as a legitimate outcome. For example, programs that address long-term problems, such as certain childhood emotional disabilities, may not see immediate and dramatic behavior changes as a result of services; however, they may see improvement in parents' feelings of self-efficacy and coping ability. This is an important outcome, but it will not be discovered if it is not measured.

On their part, researchers should continue to develop the concept of empowerment, including procedures for measuring it. While we have discussed three types of empowerment here, this view is by no means the only way of thinking about empowerment. There are likely other aspects and nuances of empowerment that have yet to be discussed and studied. In particular, additional efforts should be directed towards exploring cultural issues surrounding the concept of empowerment, since there is no reason to assume that the same definitions and connotations apply to all cultural groups. For example, cultures that place more emphasis on the community in relation to the individual are likely to have a different view of empowerment than the dominant culture view. Research and Training Center staff plan to conduct such a study involving individuals from different groups of color, and certainly more research in this area is needed if the concept of empowerment is to evolve.

Given careful attention to the practice, definition and measurement of empowerment, the concept is likely to serve as a guiding principle in the design and conduct of human services in the years to come. Without this attention, empowerment may go the way of so many other human service concepts whose time has come and gone.

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REFERENCES

Koren, P., DeChillo, N. & Friesen, B. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. *Rehabilitation Psychology*, 37(4), 305-321.

Solomon, B. (1976). *Black empowerment: Social work in oppressed communities.* New York: Columbia University.

Staples, L. (1990). Powerful ideas about empowerment. *Administration in Social Work*, 14(2), 29-42.

JUST WHAT IS "COLLABORATION"?

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collaboration is the new and evolving nature of the concept. Within the field of children's mental health, collaboration has first and foremost been discussed as a principle that signals a departure from the usual approach to delivering services. This principle states that collaborative relationships or partnerships between family members of children with emotional disorders and the professionals with whom they work will produce better outcomes for children and their families, as well as more satisfactory working relationships for all involved. The shift toward collaboration appears to have arisen primarily as a result of families long-standing dissatisfaction with services provided to them on behalf of their relatives with emotional disorders. Families have often felt blamed for the illness of a family member or alienated from the professionals providing treatment. Other important factors contributing to increased interest in collaboration include: (1) the general recognition of consumers rights in the past few decades; (2) research evidence discrediting theories of family interaction as causative agents of emotional and mental disorders and supporting the biological etiology of the most severe disorders; and (3) the reality of shrinking resources within the formal service system that has necessitated the utilization of informal resources in service planning and delivery.

While there has been much discussion about collaboration as a principle or value, only recently have there been efforts to develop it beyond this stage. For example, one important line of development is the effort to identify the major components of collaboration. A number of authors have proposed various lists of activities considered to be examples of collaboration. Drawing upon this early work, a recent survey undertaken by the Research and Training Center attempted to identify the most distinct elements of collaboration from the perspective of family members. The findings from the study revealed four major elements: (1) the support and understanding shown by professionals in their relationships with family members, e.g., including families in decisions about the child and recognizing that families have responsibilities other than their child with a disorder; (2) the assistance given to families in the practical aspects of getting services for their child, e.g., helping families find, coordinate and pay for services; (3) the clear and open exchange of information between families and professionals; and (4) the flexibility and willingness on the part of professionals to modify or change services based upon parental feedback. Other research in the future might identify additional elements of collaboration or re-define those listed here; nevertheless, this study illustrates how research can focus attention on collaboration in a way that is potentially useful to practitioners and families.

In a similar vein, the development of collaboration as a principle can benefit from studying the experiences of those who have tried to practice it in their day-to-day activities. Another recent study conducted by the Research and Training Center surveyed individuals who had received collaboration training about their experiences. Though the sample size was relatively small (52 individuals), it was equally divided between family members and professionals. In order to maximize the utility of the information collected, the survey had two parts, a self-report questionnaire, followed by a qualitative interview. Of particular interest in the survey were respondents' experiences concerning barriers to collaboration, negative consequences experienced when attempting to collaborate, and the nature of collaboration—is a collaborative relationship between a parent and a professional any different than good, professional practice?

Families and professionals generally agreed that three of the biggest barriers to collaboration were: (1) insufficient time due to high caseloads; (2) families past negative experiences with professionals; and (3) the professionals' lack of cultural competence in service delivery. More than half of the family respondents also noted the following barriers to collaboration: (a) professionals' beliefs that families cause children's disorders; (b) insufficient administrative support for staff; (c) policies that require giving up custody of a child to get services; (d) the inherent power imbalance between professionals and family members (e) and professionals lack of knowledge about children's disorders and their high expectations of families.

Almost two-thirds of parents and one-half of professionals indicated that they had experienced negative consequences because of their attempts to collaborate. Many family members cited their frustration due to professional inaction, and a few noted that their children, both those with and without disorders, were negatively affected by their attempts to be collaborative. Professionals also identified specific barriers that they had experienced. Many noted disrespect and negativity by some of their colleagues which resulted from their attempts to work collaboratively with family members.

Is collaboration merely the same as good professional practice? The majority of our respondents strongly disagreed. Both the parents and professionals noted that collaboration differs from good practice because collaboration requires partnership, reciprocity and equality. The overarching characteristic of collaboration is the shared power and responsibility of the family and the professional. Within such a working relationship, the professional must recognize the family as a valuable resource in the care and treatment of the child, appreciating the family's unique perspective and knowledge. These characteristics differ from tra-

ditional good practice. While many well-meaning professionals may tend to minimize the differences between good practice and collaboration, up until fairly recently, the ideas of collaboration and partnership in a helping relationship were not explicitly mentioned in educating helping professionals. Certainly the ambiguity still surrounding the principle of collaboration continues to blur the distinction.

The studies outlined here illustrate how research can tap the experiences of families and professionals to develop a better understanding of collaboration in an applied context. However, much work remains to be done to promote collaboration as a mainstream principle for professional practice. Some areas to be explored more fully:

- **More attention should be directed to how families can promote collaborative relationships.** A great deal of the literature on family/professional collaboration addresses what professionals can do to be more collaborative with family members. This emphasis on the responsibility of professionals is appropriate given the role of professionals in most helping relationships; after all, professionals are paid to work with children and families. But while the professionals often hold the primary responsibility, the essential role of family members should not be neglected. Collaboration is a two-way street.

- **More attention should be given to developing collaborative practice with families in especially difficult circumstances.** A frequently heard comment is that collaboration is fine with nice families, but not possible with families who have a history of child abuse, substance abuse, or other severe problems. This comment reflects a real concern that advocates of collaboration have yet to address. The possibility of collaboration with families with such difficulties should not be prematurely dismissed. We believe that much can be learned from efforts to apply collaborative practice to all families, even those who might have previously been labeled unworkable. Such efforts may well reveal new insights and developments that would not otherwise be realized for lack of trying.

- **More attention should be directed toward developing measures of collaboration that can be used in evaluation and research.** If collaboration is to become a common feature of service delivery, it must be specifically addressed in evaluations of service process and effectiveness. The Research and Training Center has done some work in developing a measure of collaboration from the perspective of family members, but more work is needed on several fronts. In particular, attention should be directed toward developing a measure of collaboration from the practitioner's point-of-view, and research on identifying key elements of collaboration should continue.

These are only a few of many possible directions for further developing the concept of collaboration. This development is necessary, or collaboration faces the same fate of many ideas in the human services that have enjoyed brief recognition only to fade away for lack of refinement or maturation. The goal is to reach a point where the dominant question about collaboration is not "What?" or "Why?"—but "Why not?" The goal is widespread recognition that, like great partnerships in other fields of human endeavor, success in childrens mental health is best achieved by merging the unique talents, perspectives, and abilities of everyone who has a stake in the outcome. Imagine Lou Costello doing the "Whos on First?" routine without Bud Abbott. Where would Bert be without Ernie? With efforts by advocates, parents, practitioners, and researchers, collaboration can progress from an intriguing principle held by a few to an established competency practiced by many.

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STUDYING FAMILY EMPOWERMENT AND PARENTAL INVOLVEMENT IN THEIR CHILD'S MENTAL HEALTH TREATMENT[1]

A major issue that continues to confront the mental health service system is the role of the family in mental health services, especially salient when the client is a child. The family plays both direct and indirect roles in the formal mental health services sector, from directly determining whether and when the child enters treatment to indirectly providing the context within which all therapeutic gains are played out. Changes in the service system and treatment philosophy that promote the use of community-based services have resulted in many more children with serious emotional disorders living with or near their families. Researchers, parent advocates, and policy analysts agree on the importance of involving parents and other family members in the process of meeting the mental health needs of children and adolescents. Some propose that parental involvement should be encouraged because of its end product—improved outcomes for children and families (1). Others (2) support the process itself, arguing that the process of involving families has intrinsic value and that it satisfies an ethical obligation to parents and families in our society, prior to any consideration of outcome.

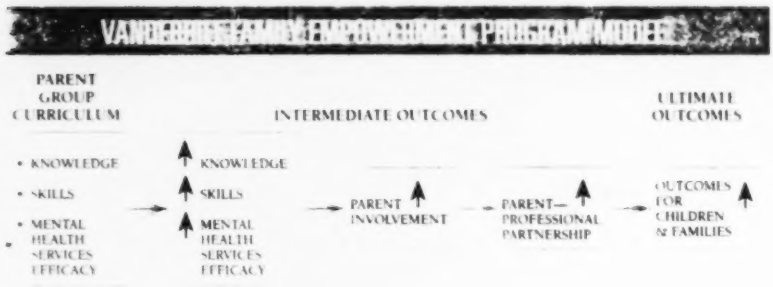
Regardless of the process versus outcomes orientation, it must be rec-

ognized that the family facilitates the interaction between the child and the service system (3). In other words, the relationship between parents and professionals is a central dimension of children's mental health services—a dimension that should be examined and strengthened. A partnership model of parent-professional interaction, where both parties join together to determine and meet information and treatment needs, calls for new roles on the parts of both parents and professionals.

The new practice models that promote parent-professional partnership are being implemented in professional training programs and policy and are slowly beginning to make an impact at the street level where parents and professionals come together face to face. More emphasis is needed, however, on the parent side of the interaction. Parents play an equally important role in determining whether their relationship with professionals will be collaborative, and programs that focus on parent roles are also needed to promote partnership. Family empowerment is a specific goal toward which parent-focused programs should aspire. Although many definitions and approaches to family empowerment have been used in the past decade, most focus on promoting access to resources, competence, and self-efficacy (4). Vanderslice (5) summarized empowerment as a process through which people become more able to influence those people and organizations that affect their lives and the lives of those they care about (p. 2).

The Vanderbilt Family Empowerment Project[2] developed a parent group curriculum and research program to study the effects of family empowerment. Empowerment in this project was operationalized as enabling parents to become collaborators in their children's mental health treatment. A series of eleven hour training programs, conducted over three days or evenings during a two week period, focused on:

information about the nature of the mental health system, the diagnostic process, how to assess



the child and family's needs, and the rights parents have in dealing with the system;

training in specific areas of assertiveness, communication and goal setting; and

beliefs that influence the parents relationship with professionals working with their children, including beliefs that parents could and should become more active in their children's mental health treatment.

Bandura's model of self-efficacy (6) provided a focus that had not been included in prior parent group materials available and formed the theoretical background for the curriculum methods and the related research questionnaires that were developed. Three effective training techniques reported in prior studies of self-efficacy were incorporated into the curriculum:

, or practice in a structure setting that leads to a successful experience;

or modeling, seeing or visualizing other similar people perform successfully; and

to try to persuade people to believe that they possess capabilities that will enable them to achieve what they seek.

Another critical component of the group-level intervention was the composition of the training team, which consisted of a professional trainer and a parent advocate. The professional trainer provided the structure and knowledge about the service system and other materials used. The parent trainer provided an important model for the parent participants and promoted group participation. The modeling and verbal persuasion provided by this parent trainer was viewed as a critical element in affecting mental health services efficacy. The more believable the source of information, says the self-efficacy literature, the more likely the observers personal efficacy judgments are to change.

Materials for the parent group curriculum were assembled to the greatest extent possible from other resources, sometimes in entirety, sometimes in part, and sometimes in modified form. A wealth of resources exists from other parent support groups and training programs, for example the Families as Allies project at Portland State University's Research and Training Center on Family Support and Children's Mental Health. When existing resources could not be found, they were developed by the curriculum authors. As mentioned above, the use of self-efficacy building methods and the emphasis on a partnership model of parent-professional relationships were the unique foci of this curriculum.

The Vanderbilt Family Empowerment Project model of family empowerment was used to guide both the curriculum development and the research design. It was hypothesized that the curriculum focusing on knowledge, skills and mental health services efficacy (above chart) should lead to an increase in each of these areas that are seen as critical elements of family empowerment. These intermediate outcomes should ultimately lead to increased parent involvement that, in turn, should lead to increased opportunities for parent-professional

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partnership. Ultimately, improved outcomes to the child and family were expected.

An experimental research design was used to study the effectiveness of the empowerment curriculum based on this model. Parents who agreed to participate filled out pre-test questionnaires, were randomly assigned to the parent groups or to a control group that received no similar services, and then filled out follow-up questionnaires at three and twelve months following the group sessions. Two hundred fifty-three parents participated. The parents had children ages six through eighteen and were receiving services from the Rumbaugh Child and Adolescent Mental Health Clinic[3] in Fayetteville, North Carolina.

A new questionnaire, the Vanderbilt Mental Health Services Efficacy Questionnaire, was designed to measure a parent's belief that he or she could engage in those activities that were necessary to affect how his or her child was treated, and that if he or she did engage in these activities, this would lead to more appropriate treatment for the child and ultimately to more positive outcomes (7). A scale for measuring parental involvement in the child's mental health treatment was also developed (8).

Results of the follow-up test demonstrated that the parent group curriculum was highly successful in attaining the desired goals (9). While—at the pre-test—the two groups of parents scored similarly, the group of parents who attended the parent group curriculum showed significantly increased knowledge of the mental health system and on mental health services efficacy. Changes in behavioral skills were not able to be tested in this setting, but the model assumed a change related to the increased knowledge and mental health services efficacy.

These results support the effectiveness of using a parent group curriculum to achieve parent-professional partnerships in children's mental health services. At the Vanderbilt Center for Mental Health Policy, we are continuing to study these data and learn more about the relationships between mental health service efficacy, parent involvement, parent-professional partnership, and child and family outcomes. In addition, we are making plans to adapt the parent group curriculum for use in other community-based settings.

For more information or copies of papers and materials from the Vanderbilt Family Empowerment Project, contact: CRAIG ANNE HEFLINGER, *Vanderbilt Center for Mental Health Policy, 1207 18th Avenue, South, Nashville, Tennessee 37212.*

NEXT ISSUE

FOCUS ON THE EXTENDED FAMILY

The next issue of *Focal Point* will explore the impact of children's mental, emotional or behavioral disorders on siblings, grandparents and other family members. While there is an expanding body of resources available to parents whose children have mental health problems, the needs of other family members have received little attention. We will offer first-person accounts by siblings and others, as well as describe their information and supportive services needs. *Focal Point* will also report upon the Research and Training Center's June 1995 *Research, Advocacy, and Partnership in Support of Children and their Families: Building on Family Strengths* conference.

FOOTNOTES

1. Preparation of this article was supported by a grant from the National Institute of Mental Health (R01MH-46136-01).
2. Developed through a grant from the National Institute of Mental Health (R01MH-46136-01), Principal Investigator, Dr. Leonard Bickman.
3. This clinic was operated as part of the Fort Bragg Child and Adolescent Mental Health Demonstration conducted by Dr. Lenore Behar and the North Carolina Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services through a contract with the U.S. Department of the Army. The Vanderbilt Center for Mental Health Policy, under the direction of Dr. Leonard Bickman, was awarded the contract for independent evaluation of the Demonstration.

REFERENCES

1. Burns, B.J. & Friedman, R.M. (1989). The research base for child mental health services and policy: How solid is the foundation? In P. Greenbaum, R. Friedman, A. Duchnowski, K. Kutash & S. Silver (Eds.), *Conference proceedings: Children's mental health services and policy: Building a research base*. Tampa, FL: Research and Training Center for Childrens Mental Health.
2. Dokecki, P.R. & Moroney, R.M. (1984). To strengthen all families: A human development and community value framework. In R. Haskins (Ed.), *Parent education and public policy* (pp. 40-64). Norwood, NJ: Ablex. Dunst, C.M., Trivette, C.M. & Deal, A.G. (1988). *Enabling and empowering families*. Cambridge, MA: Brookline Books. Friesen, B.J. (1989). Parents as advocates for children and adolescents with severe emotional handicaps: Issues and directions. In R.M. Friedman, A.J. Duchnowski & E.L. Henderson (Eds.), *Advocacy on behalf of children with serious emotional problems* (pp. 28-44). Springfield, IL: Charles C. Thomas. Hobbs, N., Dokecki, P.R., Moroney, R.M., Hoover-Dempsey, K.V., Shayne, M.W. & Weeks, K.H. (1984). *Strengthening families*. San Francisco: Jossey-Bass.
3. Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press. Stucky, P.E. & Newbrough, J.R. (1981). Mental health of mentally retarded persons: Social-ecological considerations. In H.D. Haywood & J.R. Newbrough (eds.), *Living environments for developmentally retarded persons*. Baltimore, MD: University Park Press.
4. Sokoly, M.M. (1993). *Parent-professional relationships and family empowerment: Developing a framework for understanding*. Unpublished

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doctoral dissertation. Vanderbilt University, Nashville,TN.
5. Vanderslice, V. (1984). Empowerment: A definition in progress. *Human Ecology Forum*, 14(1), 2-3.
6. Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice-Hall. Bandura, A. and Adams, N.E. (1977). Analysis of self-efficacy theory of behavioral change. *Cognitive Therapy and Research*, 1(4), 287-310. Bandura, A. Adams, N.E. & Bever, J. (1977). Cognitive processes mediating behavioral change. *Journal of Personality and Social Psychology*, 35(3), 125-139.
7. Bickman, L.B., Earls, L. & Klindworth, L. (1991). *Mental Health Services Efficacy Scale*. Unpublished scale. Vanderbilt Center for Mental Health Policy, Nashville, TN. Bickman, L.B., Heflinger, C.A. & Northrup, D.D. (1993, November). Family empowerment: A theory-based family curriculum and evaluation. Paper presented at the *Annual Conference of the American Evaluation Association*. Dallas, TX.
8. Sonnichsen, S.E. (1994). *Development of scales of parental involvement for the Family Empowerment Project*. Unpublished document. Vanderbilt Center for Mental Health Policy, Nashville, TN.
9. Northrup, D.D., Bickman, L.B. & Heflinger, C.A. (1994, April). The family empowerment project: A theory-based family intervention and evaluation. Paper presented at the conference *Building on family strengths: Research, advocacy and partnership in support of children and their families*. Portland, OR.

PARENTS' PERSPECTIVE

FAMILY TO FAMILY

I have told the personal story of my family many times and how we have struggled to get treatment and services for my mentally ill son. I have seen my son be strong under the most degrading and self-defeating situations that I have ever though possible. His strength encourages me to reach inside myself to advocate for services for him and others. We have become a family that sticks together through thick and thin and never gives up on one another.

Likewise, the same strength comes to me from other families. These families have given me encouragement by their personal stories of struggles and successes and continued words of support.

My son has been in highly structured and supervised settings for the last three years. I am now told that my son is ready to come home—back into the community. This should be a time of joy for me, however it is not. It is a time of fear—fear that my family alone cannot support the intense needs that my son requires. These fears are made greater when I see the community support that I will need for his success being cut back or eliminated.

I may not personally know your family, but I know that we all share a commonality. We are families who struggle to understand the system of care. Statistics that I have heard say that only a very minimal percentage of the entire mental health budget goes to families. The system of care has all the best intentions of helping and understanding needs of families. These intentions, however, are implemented through theories of words and not actions. These theories just keep families lingering for the supports that our families need now.

My family lives in a rural community where services to families are very limited. I continually hear of community mental health budget cuts. The limited therapy and crisis supports for our children are being further cut or are available only to families the system defines as low income.

In our state more prisons are being built and vocational programs are being developed for criminals, but very little support is offered to families who have children with disabilities. I believe that is a crime! I believe the priority should be given to adults and children with disabilities for their vocational programs and improved living conditions. This support would better help their lives and would help keep them from living in the streets and being victimized. What will become of families with children who have severe disabilities? These issues cause me great concern about the future of our children.

We all have a commonality and that is: Families need support! It is important to remember that all families are unique. We are all different from one another and have our own special needs. As families we must be encouraged to take the lead in making decisions. We must also remember that we share common goals and needs.

The families who have shared their personal stories express a commonality. They need services such as in-home support, child care, respite care, crisis support, behavioral intervention, adaptations to the home for safety, training and information. Are any of these items a commonality for your family, too? We must advocate for services that support and strengthen families!

I have heard the saying "strength in numbers" and I believe it is true. Family support groups, advocacy groups, service providers and legislation all need to hear your family's needs. If we support each other, anything is possible.

Families: get involved! Take the lead in making decisions and changes in your community and state. We need your help to advocate for services for our families. As others have said, "Even a small group of dedicated individuals can make a difference!" Joey Swegle, Pendleton, Oregon.

EDITOR'S NOTE: *Parents are invited to submit contributions, not to exceed 250 words, for the Parents' Perspective column.*

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HELPING PROFESSIONALS & PROGRAMS BECOME MORE FAMILY CENTERED

The Beach Center on Families and Disability at the University of Kansas is conducting a five year project, entitled the Development of Standards and Measures for Family-Centered Practice Project, to define, measure, and evaluate "family-centeredness" of services targeted toward children and their families. The Beach Center is a national Research and Training Center funded by the U.S. Department of Education's National Institute on Disability and Rehabilitation Research (NIDRR). Its mission is to conduct research about critical issues for families whose children have disabilities, and to educate parents, professionals, and policymakers about these issues.

Numerous government reports, parent advocates, and other experts advocate for a system of care that is family-centered, but what—exactly—does that term mean? How do we know whether a professional or a program is family-centered? If we had a clear idea about a definition of family-centered, then we could establish standards for family-centered practice. We could measure the level of family centeredness for the purposes of training and evaluating professionals and programs. Family-centered behavior is a valuable end in itself, yet many parents and professionals believe that it is also a means to other ends, that high levels of family-centeredness will result in better health and well-being for children and families. If we had a way to measure the level of family-centeredness, then we could conduct research about whether family centeredness results in better outcomes. We could begin to answer the question: Do family-centered approaches work?

In conducting this project, staff have attempted to build family-centeredness into the research project itself. A Participatory Action Research Committee (PARC) was formed to involve families and professionals in the design and implementation of the

research. The PARC consists of representatives of parent advocacy groups and key professionals in charge of implementing services for children and families throughout the state of Kansas. PARC members and parents in focus groups have influenced all phases of the project, from defining the term family-centered, to changing the wording on questions on the measurement scale, to assisting in selecting research sites and focus groups. This project has four major phases, to be completed over five years.

PHASE 1. **Define the term family-centered in clear and specific terms that can guide evaluation of family services across agency settings and service system.** We conducted a literature review of over 120 articles that included 28 definitions of family-centered. The literature review will be included as a chapter in a forthcoming book entitled *Family Support Policy and America's Caregiving Families: Innovations in Public-Private Partnerships*, which will be published by the Paul Brookes Publishing Company. From this review, we constructed a consensus definition of the term that we then critiqued with the help of the PARC and parents in focus groups. Based on this work, we arrived at the following definition: *Family-centered service delivery, across disciplines and settings, recognizes the centrality of the family in the lives of individuals. It is guided by fully-informed choices made by the family and focuses on the strengths and capabilities of families.* This definition highlights three key concepts: (1) the family as the unit of attention; (2) informed choice; and (3) a strengths perspective.

PHASE 2. **Develop a reliable and valid measurement scale that can be used in research and evaluation to improve the quality of services.** With the help of focus groups and the PARC, we have translated the definition and its three central concepts into a 33-item measurement scale designed to be completed by family members. It basically asks parents to rate how well they have been treated by the professionals with whom they are working. Some examples include: (1) the staff member helps us get all of the information we want or need; (2) the staff member makes decisions about my child's care without asking me what I want; (3) the staff member understands that I know my child better than anyone else does; and (4) the staff member wants us to involve as many people in our circle of family and friends as we think best.

For researchers and programs to have confidence in using this scale, we are conducting a national study to establish its validity and reliability. We ask half of the research sample to rate their best professional and half to rate their worst professional, so that we can determine if each question measures a difference between best and worst. We also ask each respondent how important each of the behaviors is to them. We have sent research packets to over 1500 households nationwide, with the help of organizations such as the Federation of Families for Children's Mental Health, Children's Medical Services in Florida, various local Fiesta Educative groups, and Families Together in Kansas. We have attempted to reach as diverse a sample as possible by translating the scale into Spanish,

reaching out to diverse racial and socioeconomic groups, and including various types of disabilities. This phase of the research project should be completed in Summer 1995. The scale and a user's manual will be available shortly thereafter.

PHASE 3: **Provide training and consultation to communities and agencies interested in improving the level of family-centeredness.** We hope to use the measurement scale as the beginning tool to help communities and service agencies evaluate what they are doing with families. Because the scale focuses on the interactions of the family with the professional, our technical assistance will also include an assessment of the larger context of service delivery at the policy and procedure level, to determine how the three central concepts of family-centeredness can be operationalized at that level.

For example, as a first step in working with a state or local mental health system, we would use the scale to obtain family ratings of the level and quality of existing service. This provides baseline information and valuable feedback to the agency. Next, parents will likely serve as trainers for staff to educate agency personnel about how to be more family-centered at both practice and policy levels. After a period of time has elapsed, the scale will be used a second time and compared to the baseline measure with the expectation that the quality of interactions will have improved.

PHASE 4: **Conduct research that explores the relationship between level of family-centeredness and outcomes.** Phase 4 addresses the questions often asked by skeptics: Why should we be more family-centered? What evidence do we have that family-centered approaches work? The specific outcomes will be determined by the families and professionals involved. For example, in a special education system, we might examine whether a higher level of family-centeredness is associated with children learning more. In the area of mental health, we might study whether a higher level of family-centeredness is associated with improvements in children's behavior at home. In a health system, family-centeredness may be associated with children's overall health status or with their rates of receiving prenatal care and immunizations.

Please submit ideas, comments or questions concerning this new research endeavor to the following: CHRIS [illegible], *Associate Professor, School of Social Welfare, University of Kansas, Lawrence, Kansas 66045; (913) 864-4720.*

FAMILY/PROFESSIONAL COLLABORATION: STRATEGIES FOR EMPOWERMENT

Family/professional collaboration is an important strategy for achieving the family-centered, community-based, culturally sensitive, coordinated care that can lead to better outcomes for children with special health needs and their families. But what exactly is family/professional collaboration and what does it look like? Do families and professionals view collaboration differently? What are the best practice models that best capture the spirit and practice of collaboration? The Family/Professional Collaboration Project together with families and professionals took on the task of answering these questions by exploring, identifying, and describing successful collaborative practice at family, community, state and national levels.

Funded by the federal Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs from 1990 to 1993, the Family/Professional Collaboration Project was based at the University of Vermont Department of Social Work under the direction of Kathleen Kirk Bishop, D.S.W. The overall goal of the project was to improve the health status of children with special health needs and their families through the promotion and facilitation of family/professional collaboration at all levels of planning, service delivery, and policymaking.

Project activities modeled family/professional collaboration and included representation of diverse participants and perspectives. Project highlights included:

conducting focus groups and meetings nationally to explore, define and describe family/professional collaboration;

developing the monograph, *Family/Professional Collaboration for Children with Special Health Needs and Their Families* (Bishop, K.K., Woll, J. & Arango, P., 1993), which reflects the collective efforts of families and professionals across the country;

conducting a qualitative, multi-site (Hawaii, New Mexico, Vermont) research study on family/social worker collaboration that highlights the behaviors, attitudes, and actions of social workers and families that foster collaborative relationships;

developing the newsletter *Collaboration News* to explore collaboration, highlight exemplary practice and feature project happenings;

developing draft guidelines for collaborative social work practice reflecting input from focus group participants; and

providing consultation, trainings and presentations on family/professional collaborative practice.

The principles of family/professional collaboration as outlined in *Family/Professional Collaboration for Children with Special Health Needs and Their Families* provide a framework for collaborative practice (See inset). Over 10,000 copies of the monograph

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have been distributed. The principles have been distributed and used widely as a guidance piece to state departments of public health, departments of children with special health needs, hospitals, schools of social work, and families who have children with special health needs and the professionals who work with them.

Because collaboration is about relationships, it is a dynamic process that continues to evolve with each encounter. There is no magic recipe for collaboration. As collaborative relationships evolve, families with professionals will shape collaboration in a way that is unique and most effective for them. The monograph illustrates this individualized approach through the diversity of the personal stories, vignettes and models shared.

From the family perspective, collaboration is absolutely essential. While professional helpers have an expertise and body of knowledge to draw from, they do not and cannot have the intensive day-to-day engagement with a child over time that gives families indisputable expertise on their own child's unique gifts and strengths. Although much official acknowledgment has been given to the importance of family participation in all decisions around the education and care of their children, there are still many barriers to establishing full collaborative partnerships.

Some of the barriers are attitudinal, vestiges of a hierarchical approach to addressing issues related to disability and illness. The mantle of expert was granted on the basis of academic credentials, not necessarily on knowledge or real-life competence based on experience with a particular child or family. Families were seen as part of the problem, not part of the solution. Because many of our social institutions reflect a hierarchical rather than participatory approach to solving problems, there are also systemic barriers to collaboration. Separate institutions have been designed to fix discrete problems in very defined ways, with little thought given to how to address complex interrelated issues.

It has taken families and professionals, fully committed to working collaboratively, to begin to define a new way of doing business and to grapple with what it means to be partners, to share turf, to actually give up some individual control for team empowerment. The principles of collaboration, as it turns out, are not a total surprise. Trust and respect, a willingness to listen with an open mind—even without a magic recipe—we all know that these are essential ingredients of collaboration. Yet how many of us are willing to give up our attitudes or question our assumptions about another person, or profession, or even ourselves? Are we willing—individually and personally—to let go of a little control or turf or history for a possibility that may yet be vaguely defined? Coming to the table with these principles ready to shine through in service of a shared vision may first require a willingness to let go of some old ways of thinking. This is the challenge before us as families and as professionals.

Through its work, the Family/Professional Collaboration Project has broadened the understanding of collaboration. It is our hope that this understanding of family/professional collaboration may prove beneficial not only to children with special health needs and their families, but to all children, families, professionals and systems of care.

PRINCIPLES OF FAMILY/PROFESSIONAL COLLABORATION

FAMILY/PROFESSIONAL COLLABORATION:

1. **Promotes a relationship in which family members and professionals work together to ensure the best services for the child and the family;**
2. **Recognizes and respects the knowledge, skills and experience that families and professionals bring to the relationship;**
3. **Acknowledges that the development of trust is an integral part of a collaborative relationship;**
4. **Facilitates open communication so that families and professionals feel free to express themselves;**
5. **Creates an atmosphere in which the cultural traditions, values, and diversity of families are acknowledged and honored;**
6. **Recognizes that negotiation is essential in a collaborative relationship; and**
7. **Brings to the relationship the mutual commitment of families, professionals and communities to meet the needs of children with special health needs and their families.**

For information and publications, please contact Kathleen Kirk Bishop, D.S.W., University of Vermont, Department of Social Work, 228 Waterman Building, Burlington, Vermont 05405; (802) 656-1156.

MARY ANN GASCHNIG, M.S.W., A.C.S.W., L.I.C.S.W., *served as Research Coordinator for the Family/Professional Collaboration Project. She is Community Development Specialist of Partnerships for Change and Adjunct Assistant Professor at the University of Vermont Department of Social Work in Burlington, Vermont.*

JANET VOHS *is Editor and Publications Director for the Federation for Children with Special Needs in Boston, Massachusetts. She is participating as a family specialist on the Partnerships for Change Project and participated in focus groups conducted by the Family/Professional Collaboration Project. She has one daughter, Jessica, age 23, who has been Janet's primary teacher on issues related to disability.*

[illegible], *served as Project Coordinator of the Family/Professional Collaboration Project. She is Project Coordinator of Partnerships for Change, Adjunct Assistant Professor at the University of Vermont Department of Social Work in Burlington, Vermont and is in private practice.*

THE PARTNERS PROJECT

The Multnomah County Partners Project in Portland, Oregon is a collaborative effort designed to provide coordinated, individualized, community-based services for children with serious mental, emotional and behavioral disorders who are receiving services from two or more of the following systems: special education, child welfare, juvenile justice, and mental health. Key cornerstones of the project include family involvement, interagency collaboration, service integration and pooling of resources to jointly fund capitated payments for flexible services. Initially funded by the Robert Wood Johnson Foundation, the funding for this demonstration project was continued for the current fiscal year by the collaborating agencies. Staff from these agencies are working to ensure that the principles of the Partners Project are embedded throughout Multnomah County's mental health system by July 1995.

One of the main goals of the Partners Project has been to create alternatives to repeated acute inpatient psychiatric treatment, residential treatment or long-term hospital placements through the use of interagency teams that include family members as equal team members. The team: (1) identifies the child's and family's needs; (2) collaborates on planning services to meet those needs; (3) tracks the outcome of those services over time; and (4) makes changes where appropriate. Thus, family members are involved in the assessment of the child and family's needs, they participate in the development of a plan, and they participate in the evaluation of the outcome of services.

In addition to family member participation on planning committees, parents and other family members also participate by serving on local advisory committees to the Partners Project. These committees meet monthly and work to problem solve interagency difficulties as well as to help the project develop policies to standardize some of their practices. The perspective of families who have current experiences with the various service systems has been very helpful to professionals serving on the advisory committee.

The opportunity for participation through the local advisory committee has had additional bonuses for family members. While Partners Project staff encouraged participation in family support organizations, they could not link families to one another due to the need to protect families' confidentiality. Participation in the local advisory group gave families a chance to interact with one another. These interactions also led to families seeking training to serve as child and family advocates, family participation in statewide advocacy efforts and parent attendance at national children's mental health conferences.

The Partners Project is designed so that each family receives the services of a managed care coordinator. The managed care coordinator may be characterized as a program director, except the coordinator does not have a clinic with walls; rather, the clinic is all over town and is composed of staff who work for a number of different agencies. The coordinator alternately serves as an advocate for services for the child and family, as an intervenor who encourages professionals to recognize family member's expertise, and as a guide to families to help them understand how to more effectively negotiate the service systems.

We are beginning to move the family support piece of the Child and Adolescent Service System Program principles from the academic setting and into practice. An example of an interaction between a family and their managed care coordinator demonstrates the project's commitment to empowering families on behalf of their children with mental, emotional or behavioral disorders. A family was regularly failing to get to their appointments on time. The parents explained that they kept oversleeping. The Partners Project managed care coordinator asked, "How about if we get you an alarm clock?" The suggestion was practical, it made sense to the family and it worked. Accordingly, with respect to outcomes, while it had initially been questionable how well this family was going to be able to meet their child's needs, in the space of a year this family made enormous strides that demonstrated their growing abilities to meet their child's needs. This is true family empowerment and—where success is measured in terms of the ability to keep families together—an example of the Partners Project success.

Even in those occasional circumstances in which a child is removed from the home, success may be gauged—in part—by the family's understanding of their circumstances. In most cases, of course, family members are viewed as allies in the treatment planning process. It is challenging, however, to provide family-centered services to such a variety of different families—especially when one reaches the conclusion that it is in a child's best interests not to be with the child's family. We do *not* do our child welfare colleagues justice if we soft sell the challenges of working collaboratively with families who experience real challenges in just meeting their children's daily needs.

There have been a few cases in which we believed that the family's desires were divergent from what was in the child's best interests and we have gone to court arguing for the child's removal from the home. Even in that situation, however, the family-centered approach has been very helpful: There have been no surprises to the families when we have had to take a position in court that is contrary to the family's position—the philosophy of family involvement means that families are informed, they know where you stand and what you feel obligated to say in court.

We *are* getting better and better about asking families what they need, listening carefully to their replies, seeking their guidance in planning services for their children, and altering treatment plans along the way. Collaboration among agencies and between family members and professionals is the foundation of the Partners Project. And we believe these collaborative working relationships have led successfully to the empowerment of families.

RALPH SUMMERS, M.S.W., *Robert Wood Johnson Foundation Project Coordinator, Office of Mental Health Services, Child and Adolescent Services Section, Mental Health and Developmental Disability Services Division, Oregon Department of Human Resources, 2575 Bittern Street, N.E., Salem, Oregon 97310; (503) 945-9739.*

THE PARTNERS PROJECT AND EMPOWERMENT: A PARENT'S PERSPECTIVE

When my family joined the Partners Project I was feeling terribly disillusioned by the mental health and child welfare professions. Up until that time my experiences with those two service systems had been very stressful and extremely difficult. When we got into the Partners Project, I was really taken aback by being asked questions like, "What do you think happened? Where do you see yourself after that?" Questions like that were such a turnaround for me.

I felt so empowered in the Partners Project because I learned—not only to ask for help—but to accept help. I also learned to trust my perceptions of things and to recognize my own strengths. An example of this is when I talked to our managed care coordinator and said I wanted us to get into family counseling. The coordinator gave me a list of mental health agencies in the community and said try this and try that. After spending about six hours of family counseling time with one therapist I decided that our time was just too precious and the sessions were too costly to justify seeing that therapist. I needed something to take home with me right then and there.

I went back to the managed care coordinator and said, "This isn't working and I'm in crisis." I told her about a private practice that I wanted our family to participate in. She said, "Go and give it a try. We can use flexible funds to pay the cost of this. You do the shopping—just let me know and I'll make sure we pay for it." That was a really terrific experience.

Before we ever even went to see the second therapist, he had us complete all of the necessary forms and background information. That meant that our first visit didn't just feel like an intake session. He immediately put us on a behavior modification program. So we were already doing our behavior modification before we even got home from the first session. It was so significant to me as a parent to have a program to work on—it was something I could hold onto; it was concrete. I think it gave my children hope, too, because they knew we were all (including their mom) working on the program. It was really healthy for all of us.

Another example of empowerment through the Partners Project was my involvement with the local advisory board. The parents on the committee got together and we realized that, for purposes of fairness, we wanted a parent and a professional to serve as co-chairs of the board. We also wanted to increase the number of parent representatives to equal the number of professional representatives to the board. We raised the issue and the professionals on the board were receptive to our proposal.

My children are stable for the first time in their lives. The Partners Project played a key role in making that happen. For the first time I really felt respected for who I am. Partners Project staff members showed respect for my whole family. The project staff's belief in us not only helped my family, it also helped propel me along to become more active as a parent advocate. Donna Shiltz-Meresh.

Donna Shiltz-Meresh, *of Portland, Oregon, is the mother of two boys, ages nine and ten. Her family received services through the Partners Project for three years.*

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COLLABORATION IN THERAPY AND PARENT EMPOWERMENT: A PARENT'S PERSPECTIVE

When my family joined the Partners Project we, like other families, needed to develop a collaborative working relationship with professionals. The collaboration we needed was different, however, than what people often envision when they think of collaboration. My family needed collaboration in therapy. All four of us were receiving treatment services. My husband was seeing a therapist. I was seeing a psychiatrist for therapy. My two kids were seeing a psychiatrist for therapy. Each of these people had a different idea about what was going on. My doctor told me one thing, the kid's doctor told them something else, and my husband's therapist offered his input too. Because we were each already seeing a therapist, our health maintenance organization wouldn't pay for us to see a family therapist.

The Partners Project was great. We found an appropriate family therapist. Partners Project staff wrote up a special contract so that we could see this therapist. The therapist served double duty—my husband and I saw him for marriage counseling and the four of us saw him for family counseling. This was very beneficial. As the primary coordinator of my children's care, it took a lot of pressure off of me. Each of the four of us heard the same information from the same person at the same time.

I felt really empowered through the Partners Project. I had tried for years to work with the school system and get help with my kids, but had not been able to do that. I had not been effective enough and I couldn't get people to listen to what I had to say. I expected our Partners Project managed care coordinator to be an advocate for my son. I didn't realize that he was going to be an advocate for our whole family. He laid a path for us to continue to walk on our own and now people listen to what we have to say.

I have a new strength inside of me that was put there by the Partners Project and by our managed care coordinator. He gave us back what we had in the beginning—that we *are* our children's parents and we *do* know what is best for our kids.

I've also served on the Partners Projects local advisory board for approximately three years and served as co-chair for part of that time. We successfully advocated for an equal number of seats for parents on the board. We redid the whole grievance procedure for families receiving services through the project. It is now much more parent friendly and guarantees that, if families file a complaint, one member of the grievance committee will be a parent. One parent also successfully advocated to get the Partners Project to pay the cost of prescriptions for non-Medicaid families without insurance.

Talk about feeling empowered! As a parent on the advisory board I had the opportunity to travel to New Hampshire and present at a Child and Adolescent Service System (CASSP) conference. That led to a trip to Washington, D.C. and the chance to speak at a Congressional briefing and luncheon attended by more than 350 people. The Congressional briefing was entitled "Child Mental Health in Health System Reform: Cost-Effective Solutions for Children and Families in Crisis." The briefing was held in the same room as Clarence Thomas' confirmation hearing. Tipper Gore, Mental Health Advisor to President Clinton's Health Care Task Force, participated in the briefing.

I had been beaten down so long that I had become like the system that beat me down. I had forgotten my strength and my children's strengths. It was an amazing thing for us to experience the managed care coordinator's complete focus on our strengths. In fact, as we began to rebuild our strength we also developed the strength to work on our weaknesses. Now that's empowerment! Maureen Hagen.

Maureen Hagen *and her husband Brent, of Portland, Oregon, are the parents of two children. The Hagen family has received services from the Partners Project for three years.*

NEW LOOK FOR FOCAL POINT

In celebration of the Research and Training Center on Family Support and Children's Mental Health's first ten years, and as we look forward to the next five years, *Focal Point* has a new look. We have a new masthead, are using recycled paper, different fonts, and more color. Over the next few issues, we will continue to refine our new format. Please let us know what you think of it.

OVERVIEW OF RESEARCH AND TRAINING CENTER PROJECTS IN THE NEXT FIVE YEARS

The Research and Training Center on Family Support and Children's Mental Health has been funded for the 1994-99 five year period by the National Institute on Disability and Rehabilitation Research, U.S. Department of Education, and the Center for Mental Health Services, U.S. Department of Health and Human Services. The new grant will continue the work of the Research and Training Center which was originally funded from 1984 through 1994. The research program of the Research and Training Center includes seventeen projects that are clustered around five themes.

■ Family Participation in Services. The family participation in services cluster is organized to study ways that family members can contribute to the planning and implementation of the program of services for their own child. A special focus of the work of this cluster is on issues of empowerment, including ways of measuring empowerment and ways of increasing empowerment. The cluster contains four projects of varying size, intensity and duration. The lead project, *Effects of Family Participation in Services: A Panel Study*, will study the effects that family participation and child and family characteristics, including informal supports, have on service effectiveness. Three smaller studies have been designed to supplement the lead project. The study of *Multicultural Perspectives of Empowerment* will examine the concept of family empowerment and the relevance of the Family Empowerment Scale to culturally diverse groups. The study of *Group Intervention to Enhance Family Empowerment* will develop and pilot test effective procedures for a group intervention to enhance family empowerment. The final project in this cluster is slated to begin in year three of the Center and will evaluate *Responsive Academic Assessment for Students with Severe Emotional Disabilities*. This study proposes to develop and evaluate an approach to academic assessment for children with serious emotional disabilities that engages all relevant parties, including families, fully in the process.

■ Family Participation at the Policy Level. This cluster presents a focus on the issues and constraints encountered when parents of children with serious emotional disabilities become members of decisionmaking bodies that plan, evaluate and coordinate services. Special emphasis in this cluster is on ways of involving minority family members at the policy level. The work of this cluster is organized around two major projects and one auxiliary effort. The two major studies are interrelated and will require joint staffing and joint decision making. *Family-Centered Policy: A Study of Family Member Representation at the Policy Level* will identify, evaluate and compare the effectiveness of state-mandated parent participation on boards and committees that coordinate, plan and evaluate services for children with serious emotional disorders. The second major study in this cluster, *Increasing Multicultural Parent Involvement*, will identify and evaluate strategies for conducting outreach to minority families and increasing minority family participation on advisory bodies that influence children's mental health policy and services. The third study in this cluster, *Evaluation of a KANWORK Contract* is a smaller project that features a collaborative relationship with a parent organization in Kansas. This project will evaluate a parent-directed work and training program designed to employ low income and minority families of children with serious emotional disorders in positions that allow them access both to decisionmaking and advocacy processes.

■ Families and Out-of-Home Care. The third cluster examines issues related to services that are provided to children who cannot live at home and the relationship of the family to this type of program. There are two major concentrations in this cluster, each led by a major study. The first focus is on family support and the role family support plays in helping children stay at home. The second focus is on out-of-home treatment resources and the contribution that family members can make to the effectiveness of treatment when their child is not living at home.

The lead project for the family support focus, the *Family Caregiver Panel Study*, will identify and evaluate factors that support and empower families and evaluate the impact that supports provided to families has on the effectiveness of services provided. Related to this focus, the *Support for Working Caregivers* study will examine factors that enhance the ability of employed family members to balance their work and caregiving responsibilities.

The lead study focused on out-of-home placement, *Family Participation in Residential Treatment Programs*, examines the relative influence of multiple dimensions on the effectiveness of residential treatment settings, with an emphasis on family participation. A related study, *Families and Therapeutic Foster Parents as Partners*, will examine the supports needed and used by therapeutic foster parents and biological families of children with serious emotional disorders. *A Secondary Analysis of Engagement and Placement in Families Served by Multiple Systems* will evaluate the degree of engagement in family preservation programs among families with children receiving services from multiple systems through the analysis of an existing child welfare data base.

■ Evaluation of Family Organizing Efforts. The *National Evaluation of Statewide Family Support Networks* will evaluate the effectiveness of the 28 statewide family support networks

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funded in September 1993 for a three year period by the Center for Mental Health Services. The aims of the family support networks are to: (1) provide family support and advocacy to families of children with serious emotional disorders; (2) work toward a community-based, culturally competent, family-centered system of care; and (3) develop the infrastructure of the statewide family network. Already underway, the national evaluation is a systematic study of these aims through the collection of common data elements that measure aspects of family support, system change and infrastructure development.

Interventions in Professional Education. This cluster includes three projects that are aimed at improving the relevance and responsiveness of professional education in preparing service providers, administrators, and researchers to work on behalf of children with emotional disorders and their families. *Family Participation in Professional Education: An Intervention* involves a collaboration designed to increase the participation and influence of families and family organizations in the preparation of human service and mental health professionals. *Development of a Teacher Education Curriculum: Promoting Family Partnerships for Inclusive Classrooms* involves the design, implementation and testing of a curriculum to promote family-centered approaches and family partnerships in the education of children. Beginning October 1995, *A Model of Family Participation in Therapeutic Preschools for Children Who Have Emotional Disorders* will develop, implement, evaluate and disseminate a model of family participation that is applicable to therapeutic preschools for children with emotional disorders.

For additional information on the Center's new research projects contact: Kaye Exo, M.S.W., Center Manager, Research and Training Center on Family Support and Children's Mental Health, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-5558; E-Mail: kje@rri.pdx.edu

ANNUAL RESEARCH CONFERENCE SCHEDULED FOR JUNE

The Research and Training Center on Family Support and Childrens Mental Health will hold its annual research conference June 1-3, 1995 in Portland, Oregon. The conference, entitled **Building on Family Strengths: Research and Programs in Support of Children and Their Families**, will bring together family members, researchers, policy-makers, service providers, educators and advocates interested in strengthening research and practice in response to the needs of children and families. Presentations will include research reports and innovative program descriptions and evaluations that address four conference themes: family research methods, family participation in policy and services, family support and family diversity.

Keynote speaker for the conference will be Karl Dennis, nationally recognized pioneer of wraparound services, who will discuss these services and their meaning for families, professionals and researchers. A popular lecturer and consultant, Mr. Dennis is an expert on community-based, intensive in-home services.

Peter Jensen will address the implications of research advances in children's mental health for service providers, families, and researchers. Dr. Jensen, a board-certified child and adolescent psychiatrist and psychiatric researcher, is Chief of the Child and Adolescent Disorders Research Branch of the Division of Clinical and Treatment Research at the National Institute of Mental Health.

Carol Williams and Velva Spriggs will jointly present a plenary session on family-centered culturally competent systems of care. Dr. Williams, who is Associate Commissioner of the Children's Bureau in the Department of Human Services Administration for Children and Families, is responsible for the management of programs that focus on strengthening and supporting families. Ms. Spriggs is active in the family movement, a founding member of the Family Advocacy and Support Association, Inc., in Washington, D.C., and the parent of a child diagnosed with a serious emotional disorder. She is the Director of Planning and System Development Programs in the Child, Adolescent and Family Branch of the Center for Mental Health Services.

A panel of family members and researchers will present positive examples of researcher-family collaboration. Panel members include Mary Telesford, Annie E. Casey Foundation Site Advisor at the Federation of Families for Children's Mental Health, and researcher-family partners from Johns Hopkins University and the University of Maine.

For conference registration materials and further information, please contact: Kaye Exo, Center Manager, Research and Training Center on Family Support and Children's Mental Health, Portland State University, P.O. Box 751, Portland, Oregon 97207-0751; (503) 725-5558; E-Mail: kje@rri.pdx.edu

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